CLIENT RIGHTS CONSENT

Client's Legal Name_________________________________ DOB: _________________ Client Record # ________________

_______ (Initial here once informed) **Restrictive Interventions**

I, give permission to the above-mentioned agency to perform restrictive intervention on when all other methods have been exhausted when trying to deescalate the above-mentioned consumer. Following the utilization of a restrictive intervention, staff shall conduct debriefing and planning with to eliminate or reduce the probability of the future use of restrictive interventions. I understand that this consent is only valid for unplanned restrictive interventions and is not invalid unless the client or legally responsible person chooses to withdraw the consent.

_______ (Initial here once informed) **Suspension and Expulsion from Service**

I , understand the if I do not comply with the rules outlines by the agency and becomes a possible threat to others served within this agency he/she maybe possibly suspended or expelled from services. I understand that this would be the agency's last result before assessing the client to see if he/she meets the criteria to discharge. However, if it results in discharge the agency will follow its due process procedure before exhausting all other means.

_______ (Initial here once informed) **Search and Seizure**

I understand that each client shall be free from unwarranted invasion of privacy. However, I understand that searches of my child's living area may occur. I, also give permission to the agency to perform random planned or unplanned searches and seizures on my child's belongings, or property in his/her possession. I understand that each search will be documented to include; scope of search, reason for search, procedures followed in the search, description of any property found and an account of the disposition of seized property.

_______ (Initial here once informed) **Carolina Legal Assistance**

I understand a written summary of client rights shall be made available to each client and legally responsible person. I have been informed of his/her right to contact The Carolina Legal Assistance who assumed the role of the (GACPD) , the statewide agency designated under federal and state law to protect and advocate the rights of person with disabilities.

_______ (Initial here once informed) **Admissions into Services Agreement**

I understand that I shall be informed of services rendered by this agency upon admission or entry into services.

_______ (Initial here once informed) **Agency Rules**

I understand the rules that I am/my child is expected to follow and possible penalties for violation of the rules.

_______ (Initial here once informed) **Consent regarding Disclosure of Confidential Information**

I understand that the agency will follow its policy as it relates to protecting my rights regarding disclosure of confidential information, as delineated in G.S. 122C-52 through G.S. 122C-56.

_______ (Initial here once informed) **Consent regarding Treatment**

I give permission to **Firm Foundation, Inc.** to obtain a copy of my/my child's treatment / Habilitation plan and/or other information that relates to him/her in order for the agency to adequately serve.

_______ (Initial here once informed) **Fee Assessment**

I understand that I will be responsible for fees assess by my child that Medicaid does not cover as it relates to the treatment of my child. I understand that the agency will do everything possible to avoid collection from me/my child on behalf of treatment/habilitation services rendered.

_______ (Initial here once informed) **Grievance Procedure**

Client's Legal Name________________________________ DOB: _________________ Client Record # ________________

I understand that I/my child has the right disclose any grievances that he/she may have as it relates to the agency. I understand that **Firm Foundation, Inc.** will be provided a description of the assistance that the agency will be provided. I understand that the agency will be provided the results of any grievance submitted on behalf of my/my child. I understand that he/she will be given a chance to dispute the results of his/her grievance if the findings are not to his/her satisfaction. I understand that I can contact Carolina Legal Assistance who replaced (GACPD)/or the Local Mental Health LME.

_______ (Initial here once informed) **Informed of Client Rights**

I understand and have been informed of and received a copy of the Client Rights handbook, which includes information on Client's Rights, HIPPA, and Privacy and Confidentiality. I understand the consent forms are valid unless the client or legally responsible person chooses to withdraw the consent. I have received, and had been explained my Rights to Privacy. **Firm Foundation, Inc.** gave me a copy of the Client Rights handbook and I understand these rights, which are designed to protect the privacy of me/ and/or my child.

_______ (Initial here once informed) **Social Integration**

I give **Firm Foundation, Inc.** my permission to allow my child to participate in appropriate and generally acceptable social interactions and activities with other clients and non-client members of the community. My child shall not be prohibited from such social interactions unless restricted in writing in the client record in accordance with G.S. 122C-62 (e).

_______ (Initial here once informed) **Emergency Medical Treatment**

I give **Firm Foundation, Inc.** my permission to seek emergency care for my child from a hospital or physician. I also give **Firm Foundation, Inc.** the consent to seek and sign consent for preventive and emergency medical care for my child in my absence. It is understood that **Firm Foundation, Inc.** will attempt to contact me, or another designated responsible adult as soon as possible in the event of an emergency.

_______ (Initial here once informed) **Disaster and Risk Management Plan**

I have been informed and received a copy **Firm Foundation, Inc.** Disaster Preparedness Plan and Risk Management Practices. I understand the consent forms are valid unless the client or legally responsible person chooses to withdraw the consent.

_______ (Initial here once informed) **Financial Release**

I have been informed and received a copy **Firm Foundation, Inc.** may use confidential information about me to bill and be paid for services. I hereby consent **Firm Foundation, Inc.** to release information to NC TRACKS (the State of NC managed care vendor) and/or the referring Area Program.

_______ (Initial here once informed) **Transport**

I have been informed and received a copy **Firm Foundation, Inc.** to provide transportation to my child, and agree to hold **Firm Foundation, Inc.** harmless for any accident/injury that results from the provision of transportation.

I understand that, with certain exceptions, I have the right to revoke this authorization at any time. If not revoked earlier, this consent shall be valid for one year from the signed unless otherwise indicated below:

________________________________ ______________ ________________________________ ______________

Signature of Client or Legal Guardian Date Signature of Agency Representative Date

Federal health privacy law (45 C.F.R. Parts 160, 164), the federal drug and alcohol confidentiality law (42 C.F.R. Part 2), and the state confidentiality law governing mental health developmental disabilities and substance abuse services (G.S. 122C)

EMERGENCY CONTACT FORM

I ____ (Client or if Minor Legal Guardian), give Firm Foundation, Inc. and the providers of Firm Foundation, permission to access the following contacts in case of emergency and to provide medical attention necessary to myself/child.

Client Name: ____ DOB: ________________________

EMERGENCY CONTACT PERSON

1st Emergency Name: ______________________________________ Relationship: _______________________

Work or Cell Phone Number: ________________________________

Address (Street, City, State, & Zip): ____

____

EMERGENCY CONTACT PERSON

2nd Emergency Name: ______________________________________ Relationship: _______________________

Work or Cell Phone Number: ________________________________

Address (Street, City, State, & Zip): ____

____

PREFERRED LICENSED MEDICAL PROVIDER

Name: ____

Address: ____

City: ____ State: ______________ Zip: _________

Office Phone: _________________________________

Notice Regarding Potential Emergencies:
____

Routine Medical & Dental Treatment:
I hereby give permission to the staff of Firm Foundation, Inc. to seek routine medical and dental treatment on behalf of the above-named client.

Emergency Medical Treatment:
In case of sudden illness/accident/emergency, I hereby give permission to the staff of Firm Foundation, Inc. to seek to seek emergency treatment on behalf of the above-named client should the need arise. It is understood that a licensed medical provider and/or hospital emergency room personnel will provide this treatment. In addition, a copy of current medications, known medical conditions and allergies may be released. Efforts will be made to contact a person named below prior to treatment, should this be possible.

The above consent has been read by me or to me and explained to me by an employee of Firm Foundation, Inc. to seek. I agree with the above consents as evidenced by the signature below.

____ _________________ _________________
Client Signature (If Minor Legal Guardian) Relationship Date

____ _________________
Firm Foundation Clinician/Authorized Representative Signature Date

PERMISSION FOR ADMINISTERING NON-PRESCRIPTION MEDICATION

As the physician/parent/guardian/custodian of ________________________________ I agree to allow the staff and foster parents of (Firm Foundation, Inc.) to administer the following non-prescription medications only as needed for periodic treatment of condition as described below:

(Signature of physician is required if the client is currently taking prescription medication)

EXTERNAL

	Medication	For Treatment of
1.	Neosporin or antibiotic ointment	Minor burns, cuts, abrasions
2.	Calamine lotion (with or without Phenol)	Allergic rashes (poison ivy, poison oak, etc.)
3.	Rubbing alcohol	Insect bites
4.	Betadine scrubs or soap and water	Cleaning area of minor injury

INTERNAL

	Medication	For Treatment of
1.	Acetaminophen tablets (Tylenol, Datril,	Headaches or minor pain (Panadol, etc.)
2.	Pepto Bismol liquid	Upset stomach
3.	Kaopectate liquid	Diarrhea
4.	Chlortumeton tablets Chlorpheninamine (antihistamine)	Common cold or minor allergic reaction to insect bites
5.	Dextromethorphan (lozenge and spray form)	Cough
6.	Cepacol or chloraseptic lozenge	Sore throat
7.	Mineral oil	Constipation
8.	Milk of Magnesia	Constipation
9.	Benadryl capsules	Allergic reaction (bee stings)
10.	Ipecac syrup	Induce vomiting (clear with (doctor and/or emergency room Before administering)

Please X out above if your child has a known allergy to any of these medications or you have an objection to the administration of any of these medications.

____ ______________

Signature of Physician Date

(Signature of Physician is required if client is currently taking prescription medication)

____ ______________

Signature of Parent, Guardian, or Custodian Date

Non-prescription medicines are to be administered according to package directions and only for symptoms listed on the package labeling. If symptoms persist, the client physician will be consulted.

VISITATION and CONTACT PLAN

For each child, state type, time, level of supervision, frequency, duration, location of visits, and transportation arrangements. Revise as often as necessary. If children are separated, also include a plan for sibling visitation. Different forms should be completed when the children have different visitation plans.

Child(ren) Name(s):	

This plan is effective through date:	

Supervision Required: ☐ **Yes** ☐ **No** **By Whom:**
Place of visit:
Frequency of visits:
Hours:
Length of visits:
Transportation Arrangements:
Special Considerations:
Phone Calls Allowed: ☐ **Yes** ☐ **No**
With Whom: **Monitoring Needed:** ☐ **Yes** ☐ **No**
Monitoring Needed: ☐ **Yes** ☐ **No**
Mail/Email Allowed: ☐ **Yes** ☐ **No**
From Whom: **Monitoring Needed:** ☐ **Yes** ☐ **No**
Monitoring Needed: ☐ **Yes** ☐ **No**
Send All Mail/Email to:

Signatures:

Child/Youth (if appropriate): ______________________________________ Date: ___________
Parent(s): ____ Date: ___________
Social Worker: ____ Date: ___________
Others: ____ Date: ___________

DSS-5242 (02/06) Family Support and Child Welfare Service

VIDEOTAPE / PHOTOGRAPH / RESEARCH CONSENT FORM

I hereby authorize Firm Foundation, Inc. to MAKE and USE the following of ______________________________
(Check all boxes consumer authorizes by this consent) (Client's name)

- Audio-Visual recordings
- Photograph of my image

The agency will use these recordings for the purpose of identification, promotional and public awareness.

I understand that this authorization will be time-limited until discharge from the program and that I have the right to change or revoke this consent at any time.

OR

I decline authorization of audio-visual recordings and/or photographic imaging of

_____________________________ ____________
(Client's name) initial here

 I hereby authorize ________________________ to participate in research being conducted on behalf of Firm Foundation, Inc.
(Client's name)
I understand that this authorization will be time-limited until discharge from the program and that I have the right to change or revoke this consent at any time.

OR

 I decline authorization for __________________________ to participate in research being conducted on behalf of Firm Foundation, Inc.
(Client's name)

____
Client signature (required if age 12 or older)

____
Date

____
Parent, guardian or legal custodian signature

____
Date

Consent to Release Personal and Medical Information

I, ____ hereby request and authorize
(*Client Name or Legal Guardian if Minor)*
Firm Foundation, Inc. to use or disclose my protected health information to the following:

Mental Health Provider: ____

Client Name (Print):____ DOB: ______________

Information released may be *verbal, electronic, or written* and allows for a reciprocal exchange of information. Released data may include records, treatment notes, and other information.

Nature of records to be released: (***Please initial beside each applicable document***)

- ☐ Medications
- ☐ Treatment Plans
- ☐ Treatment Recommendations
- ☐ Psychiatric Evaluations
- ☐ Psychological Evaluations
- ☐ Progress/Psychotherapy Notes
- ☐ Discharge Summaries
- ☐ Aftercare Plans/Orders
- ☐ Alcohol/Drug Treatment
- ☐ Clinical Assessments
- ☐ IEP/School Records
- ☐ Other: ________________

I understand the purpose of the disclosure/redisclosure will be used for: Mental Health Treatment

My signature below indicates that I understand what information will be released and the need for the information. I further understand that the information to be released may include information regarding drug and alcohol abuse or HIV infection, AIDS, or AIDS related conditions. This information shall be released only in accordance with NCGS §130A-143. In addition, information related to drug and alcohol abuse in my records is protected under federal regulations and cannot be released without my written consent unless otherwise provided in 42 CFR Part 2. Once information is disclosed pursuant to the signed authorization, I understand that the federal privacy law (45 CFR Part 164) protecting health information may not apply to recipient of the information and, therefore, may not prohibit the recipient from redisclosing it. Other laws, however, may prohibit redisclosure. When we disclose mental health, intellectual and developmental disabilities information protected by state law (G.S. 122C) or substance abuse treatment information protected by federal law (42 CFR Part 2), we must inform the recipient that redisclosure is prohibited except as permitted or required by these two laws. Our Notice of Privacy Practices describes the circumstances where disclosure is permitted or required by these laws.

This consent will expire on ________________not more than 365 days from the date of signature.

When this authorization is requested from the client, a copy of this signed release form shall be provided to the client or legally responsible person. The client authorizing the release of this information also may inspect or copy the health information disclosed as permitted by NCGS § 122C-53(c).

I understand that I may revoke this consent, in writing, at any time, except to the extent that action has been taken in reliance on the consent. If you choose to revoke this consent, Firm Foundation, Inc. I understand that I may refuse to sign this release of information form. I understand that Firm Foundation, Inc., may not condition treatment, payment, enrollment or eligibility for benefits if you refuse to sign the consent form. I understand that Firm Foundation, Inc., may charge a reasonable fee for copies of my medical records.

____ ____________________ __________
Client Signature (Legal Guardian if Minor) Relationship Date

____ ___________
Clinician/Authorized Representative Signature Date

Consent to Release Personal and Medical Information

I, ____ hereby request and authorize
(*Client Name or Legal Guardian if Minor)*
Firm Foundation, Inc. to use or disclose my protected health information to the following:

Foster Parent: ____

Client Name (Print):____ DOB: _____________

Information released may be *verbal, electronic, or written* and allows for a reciprocal exchange of information. Released data may include records, treatment notes, and other information.

Nature of records to be released: (***Please initial beside each applicable document***)

- ☐ Medications
- ☐ Treatment Plans
- ☐ Treatment Recommendations
- ☐ Psychiatric Evaluations
- ☐ Psychological Evaluations
- ☐ Progress/Psychotherapy Notes
- ☐ Discharge Summaries
- ☐ Aftercare Plans/Orders
- ☐ Alcohol/Drug Treatment
- ☐ Clinical Assessments
- ☐ IEP/School Records
- ☐ Other: _______________

Purpose of use or disclosure: ***(Please initial beside each applicable document)***

- ☐ Assessment/Evaluation
- ☐ Court Proceedings
- ☐ Coordination of Service
- ☐ Determination of Benefits

I understand the purpose of the disclosure/redisclosure will be used for: Mental Health Treatment

My signature below indicates that I understand what information will be released and the need for the information. I further understand that the information to be released may include information regarding drug and alcohol abuse or HIV infection, AIDS, or AIDS related conditions. This information shall be released only in accordance with NCGS §130A-143. In addition, information related to drug and alcohol abuse in my records is protected under federal regulations and cannot be released without my written consent unless otherwise provided in 42 CFR Part 2. Once information is disclosed pursuant to the signed authorization, I understand that the federal privacy law (45 CFR Part 164) protecting health information may not apply to recipient of the information and, therefore, may not prohibit the recipient from redisclosing it. Other laws, however, may prohibit redisclosure. When we disclose mental health, intellectual and developmental disabilities information protected by state law (G.S. 122C) or substance abuse treatment information protected by federal law (42 CFR Part 2), we must inform the recipient that redisclosure is prohibited except as permitted or required by these two laws. Our Notice of Privacy Practices describes the circumstances where disclosure is permitted or required by these laws.

This consent will expire on _______________not more than 365 days from the date of signature.

When this authorization is requested from the client, a copy of this signed release form shall be provided to the client or legally responsible person. The client authorizing the release of this information also may inspect or copy the health information disclosed as permitted by NCGS § 122C-53(c).

I understand that I may revoke this consent, in writing, at any time, except to the extent that action has been taken in reliance on the consent. If you choose to revoke this consent, Firm Foundation, Inc. I understand that I may refuse to sign this release of information form. I understand that Firm Foundation, Inc., may not condition treatment, payment, enrollment or eligibility for benefits if you refuse to sign the consent form. I understand that Firm Foundation, Inc., may charge a reasonable fee for copies of my medical records.

____ ________________ _________
Client Signature (Legal Guardian if Minor) Relationship Date

____ _________
Clinician/Authorized Representative Signature Date

Revised 4.11.22

Consent to Release Personal and Medical Information

I, ____ hereby request and authorize
(*Client Name or Legal Guardian if Minor)*
Firm Foundation, Inc. to use or disclose my protected health information to the following:

School: ____

Client Name (Print):____ DOB: ______________

Information released may be *verbal, electronic, or written* and allows for a reciprocal exchange of information. Released data may include records, treatment notes, and other information.

Nature of records to be released: (***Please initial beside each applicable document***)

- ☐ School Records (attendance, grades, suspensions)
- ☐ IEP/BIP
- ☐ Birth Certificate
- ☐ Immunization Records
- ☐ Medications
- ☐ Psychological Evaluations
- ☐ Clinical Assessments
- ☐ Treatment Recommendations
- ☐ Other: ________________

Purpose of use or disclosure: ***(Please initial beside each applicable document)***

- ☐ Assessment/Evaluation
- ☐ Court Proceedings
- ☐ Coordination of Service
- ☐ Determination of Benefits

I understand the purpose of the disclosure/redisclosure will be used for: Mental Health Treatment

My signature below indicates that I understand what information will be released and the need for the information. I further understand that the information to be released may include information regarding drug and alcohol abuse or HIV infection, AIDS, or AIDS related conditions. This information shall be released only in accordance with NCGS §130A-143. In addition, information related to drug and alcohol abuse in my records is protected under federal regulations and cannot be released without my written consent unless otherwise provided in 42 CFR Part 2. Once information is disclosed pursuant to the signed authorization, I understand that the federal privacy law (45 CFR Part 164) protecting health information may not apply to recipient of the information and, therefore, may not prohibit the recipient from redisclosing it. Other laws, however, may prohibit redisclosure. When we disclose mental health, intellectual and developmental disabilities information protected by state law (G.S. 122C) or substance abuse treatment information protected by federal law (42 CFR Part 2), we must inform the recipient that redisclosure is prohibited except as permitted or required by these two laws. Our Notice of Privacy Practices describes the circumstances where disclosure is permitted or required by these laws.

This consent will expire on ________________not more than 365 days from the date of signature.

When this authorization is requested from the client, a copy of this signed release form shall be provided to the client or legally responsible person. The client authorizing the release of this information also may inspect or copy the health information disclosed as permitted by NCGS § 122C-53(c).

I understand that I may revoke this consent, in writing, at any time, except to the extent that action has been taken in reliance on the consent. If you choose to revoke this consent, Firm Foundation, Inc. I understand that I may refuse to sign this release of information form. I understand that Firm Foundation, Inc., may not condition treatment, payment, enrollment or eligibility for benefits if you refuse to sign the consent form. I understand that Firm Foundation, Inc., may charge a reasonable fee for copies of my medical records.

_______________________________________ ________________ __________
Client Signature (Legal Guardian if Minor) Relationship Date

_______________________________________ __________
Clinician/Authorized Representative Signature Date

Consent to Release Personal and Medical Information

I, ____ hereby request and authorize
(*Client Name or Legal Guardian if Minor*)
Firm Foundation, Inc. to use or disclose my protected health information to the following:

Other: ____

Client Name (Print):____ DOB: ______________

Information released may be *verbal, electronic, or written* and allows for a reciprocal exchange of information. Released data may include records, treatment notes, and other information.

Nature of records to be released: (***Please initial beside each applicable document***)

☐ Medications/Prescriptions
☐ Medical Examination/Records
☐ Dental Examination/Records
☐ Treatment Plans
☐ Treatment Recommendations
☐ Psychiatric Evaluations
☐ Psychological Evaluations
☐ Progress/Psychotherapy Notes
☐ Discharge Summaries
☐ Alcohol/Drug Treatment
☐ Clinical Assessments
☐ IEP/School Records
☐ Immunization Records
☐ Other: ___________

Purpose of use or disclosure: ***(Please initial beside each applicable document)***

☐ Assessment/Evaluation
☐ Court Proceedings
☐ Coordination of Service
☐ Determination of Benefits

I understand the purpose of the disclosure/redisclosure will be used for: Mental Health Treatment

My signature below indicates that I understand what information will be released and the need for the information. I further understand that the information to be released may include information regarding drug and alcohol abuse or HIV infection, AIDS, or AIDS related conditions. This information shall be released only in accordance with NCGS §130A-143. In addition, information related to drug and alcohol abuse in my records is protected under federal regulations and cannot be released without my written consent unless otherwise provided in 42 CFR Part 2. Once information is disclosed pursuant to the signed authorization, I understand that the federal privacy law (45 CFR Part 164) protecting health information may not apply to recipient of the information and, therefore, may not prohibit the recipient from redisclosing it. Other laws, however, may prohibit redisclosure. When we disclose mental health, intellectual and developmental disabilities information protected by state law (G.S. 122C) or substance abuse treatment information protected by federal law (42 CFR Part 2), we must inform the recipient that redisclosure is prohibited except as permitted or required by these two laws. Our Notice of Privacy Practices describes the circumstances where disclosure is permitted or required by these laws.

This consent will expire on ________________not more than 365 days from the date of signature.

When this authorization is requested from the client, a copy of this signed release form shall be provided to the client or legally responsible person. The client authorizing the release of this information also may inspect or copy the health information disclosed as permitted by NCGS § 122C-53(c).

I understand that I may revoke this consent, in writing, at any time, except to the extent that action has been taken in reliance on the consent. If you choose to revoke this consent, Firm Foundation, Inc. I understand that I may refuse to sign this release of information form. I understand that Firm Foundation, Inc., may not condition treatment, payment, enrollment or eligibility for benefits if you refuse to sign the consent form. I understand that Firm Foundation, Inc., may charge a reasonable fee for copies of my medical records.

____ ________________ __________
Client Signature (Legal Guardian if Minor) Relationship Date

____ __________
Clinician/Authorized Representative Signature Date

Consent to Release Personal and Medical Information

I, ____ hereby request and authorize
(*Client Name or Legal Guardian if Minor)*
Firm Foundation, Inc. to use or disclose my protected health information to the following:

Medical/Dental Provider: ____

Client Name (Print):____ DOB: ______________

Information released may be *verbal, electronic, or written* and allows for a reciprocal exchange of information. Released data may include records, treatment notes, and other information.

Nature of records to be released: (***Please initial beside each applicable document***)

- ☐ Medications/Prescriptions
- ☐ Medical Examination/Records
- ☐ Dental Examination/Records
- ☐ Immunization Records
- ☐ Treatment Plans
- ☐ Treatment Recommendations
- ☐ Psychiatric Evaluations
- ☐ Psychological Evaluations
- ☐ Progress/Psychotherapy Notes
- ☐ Discharge Summaries
- ☐ Aftercare Plans/Orders
- ☐ Alcohol/Drug Treatment
- ☐ Clinical Assessments
- ☐ Other: ____________

Purpose of use or disclosure: ***(Please initial beside each applicable document)***

- ☐ Assessment/Evaluation
- ☐ Court Proceedings
- ☐ Coordination of Service
- ☐ Determination of Benefits

I understand the purpose of the disclosure/redisclosure will be used for: Mental Health Treatment

My signature below indicates that I understand what information will be released and the need for the information. I further understand that the information to be released may include information regarding drug and alcohol abuse or HIV infection, AIDS, or AIDS related conditions. This information shall be released only in accordance with NCGS §130A-143. In addition, information related to drug and alcohol abuse in my records is protected under federal regulations and cannot be released without my written consent unless otherwise provided in 42 CFR Part 2. Once information is disclosed pursuant to the signed authorization, I understand that the federal privacy law (45 CFR Part 164) protecting health information may not apply to recipient of the information and, therefore, may not prohibit the recipient from redisclosing it. Other laws, however, may prohibit redisclosure. When we disclose mental health, intellectual and developmental disabilities information protected by state law (G.S. 122C) or substance abuse treatment information protected by federal law (42 CFR Part 2), we must inform the recipient that redisclosure is prohibited except as permitted or required by these two laws. Our Notice of Privacy Practices describes the circumstances where disclosure is permitted or required by these laws.

This consent will expire on _________________not more than 365 days from the date of signature.

When this authorization is requested from the client, a copy of this signed release form shall be provided to the client or legally responsible person. The client authorizing the release of this information also may inspect or copy the health information disclosed as permitted by NCGS § 122C-53(c).

I understand that I may revoke this consent, in writing, at any time, except to the extent that action has been taken in reliance on the consent. If you choose to revoke this consent, Firm Foundation, Inc. I understand that I may refuse to sign this release of information form. I understand that Firm Foundation, Inc., may not condition treatment, payment, enrollment or eligibility for benefits if you refuse to sign the consent form. I understand that Firm Foundation, Inc., may charge a reasonable fee for copies of my medical records.

____ ____________________ __________

Client Signature (Legal Guardian if Minor) Relationship Date

____ ___________

Clinician/Authorized Representative Signature Date

Consent for Treatment

I have discussed with the staff of Firm Foundation, Inc., and have agreed to receive the following indicated/requested services:

_____ Comprehensive Clinical Assessment

_____ Outpatient Therapy

_____ Therapeutic Foster Care Placement Level I and II

______ Family Foster Level I

_____ Traditional Family Foster Care

I understand that Firm Foundation, Inc. provides services that are medically necessary. Other providers and their services were reviewed with me and I understand that I may choose another provider at any time with assistance, if needed, from my current agency. I have also been informed of my right to change providers later in my treatment for any reason.

My signature below reflects my understanding of my rights, my consent of such services and my full participation and freedom of choice in the treatment planning process. I also understand that Firm Foundation will complete a Comprehensive Clinical Assessment for all levels of treatment for placement purposes. Any additional services not already indicated may be recommended, I will have further opportunity to participate in the planning of such additional services. I understand I can withdraw my consent for treatment at any time; however, if I have been court ordered to receive services, my withdrawal may be communicated to the appropriate authorities.

I understand I have a choice of provider and I have chosen Firm Foundation, Inc. I have given Firm Foundation, Inc., permission to provide the above checked services. I was asked about my cultural preferences (including my choice as consistent with my values, customs and beliefs) and if the location of service delivery was appropriate. I selected the above-mentioned agency, considering my choices and preferences.

____ ___________________

Client Name (Print) DOB

____ ____________________

Client (If Minor Legal Guardian) Signature/Relationship Date

____ ____________________

FIRM Clinician/Authorized Representative Signature Date